Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: COLLEGE STATION MEDICAL CENTER C/O SULLINS JOHNSTON ROHRBACH & MAGERS 3200 SW FREEWAY STE 2200 HOUSTON TX 77027	MFDR Tracking #: M4-08-5802-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: STATE OFFICE OF RISK MANAGEMENT Box #: 45	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The total charges for this outpatient surgery was $13,290.25. SORM only paid a total of $1,896.90 of these total charges which amounts to a reimbursement rate of less than 10% of billed charges. Since there is no established fee guideline under the acute care inpatient hospital fee guideline, this claim should have been paid at a fair and reasonable rate. A 90% reduction in total charges is not a fair and reasonable rate of reimbursement under any managed care arrangement."

Amount in Dispute: $11,393.35

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**The Office has properly submitted its consistent fair and reasonable methodology pursuant to Rule 134.1 (d)(1)(2)(3) for the outpatient services in dispute. However the requestor has failed to present any evidence of its methodology justifying the request for additional reimbursement other than its position of a non-applicable rule. The requestor has further failed to present any evidence that the reimbursement received was not fair and reasonable or ultimately resulted in a loss.**"

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
5/23/2007-5/25/2007	524, GP, W10, B15, TC	Inpatient Admission	$11,393.35	$0.00
			Total Due:	$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code § 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Medical Reimbursement*, effective May 2, 2006, and §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on May 15, 2008.

1. For the services involved in this dispute, the respondent reduced or denied payment with reason code:
   - 524 – Recommended allowance per Insurer decision
   - GP – Service delivered under OP PT care plan
   - W10 – Payment based on fair & reasonable methodology
   - B15 – Procedure/Service is not paid separately
   - TC – Technical Component
2. Division rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, 22 TexReg 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute

care hospital." Review of box 12 and 13 on the requestor's medical bill finds that the injured worker was admitted on 5/23/2007 at hour 13. Review of box 6 and box 16 finds that the injured worker was discharged on 5/25/2007 at hour 13. The submitted documentation supports that the length of stay exceeded 23 hours; the Division therefore concludes that the services in dispute are inpatient services.

3. This dispute relates to inpatient services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 TAC §134.401, effective August 1, 1997, 22 TexReg 6264. Additionally, §134.401(c)(4)(B)(i) provides that when "Magnetic Resonance Imaging (MRIs) (revenue codes 610-619)" are performed, such services shall be reimbursed at a fair and reasonable rate. Review of the submitted documentation finds that the provider performed "MAGNETIC IMAGE, LUMBAR" CPT 72148, and "MAGNETIC IMAGE, NECK SP" CPT 72141, both billed under revenue code 612. These additional services shall therefore be reimbursed at a fair and reasonable rate.
4. Division rule at 28 TAC §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(c)(2)(B), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include "a copy of each explanation of benefits (EOB)... relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(B).
7. Division rule at 28 TAC §133.307(c)(2)(F)(ii), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not stated the reasoning for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(ii).
8. Division rule at 28 TAC §133.307(c)(2)(F)(iii), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iii).
9. Division rule at 28 TAC §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of Division rule at 28 TAC §133.307(c)(2)(F)(iv).
10. Division rule at 28 TAC §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
    - The requestor's position statement asserts that "Since there is no established fee guideline under the acute care inpatient hospital fee guideline, this claim should have been paid at a fair and reasonable rate. A 90% reduction in total charges is not a fair and reasonable rate of reimbursement under any managed care arrangement."
    - As detailed above, the primary service performed was an inpatient medical admission. The primary service has a reimbursement under the *Acute Care Inpatient Hospital Fee Guideline*. The only services which do not have an established fee guideline are the MRI services which shall be reimbursed at a fair and reasonable rate.
    - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be

calculated for the disputed MRI services.

- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
- The requestor did not submit nationally recognized published studies, published Division medical dispute decisions, or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not discuss or explain how payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement for the MRI services is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the MRI services in dispute. Additional payment for the MRI services cannot be recommended.

11. Reimbursement will therefore be calculated according to the standard per diem amount for an inpatient admission in accordance with Division rule at 28 TAC §134.401(c). Review of the submitted documentation finds that the length of stay was two calendar days. The type of admission is medical; therefore, the standard medical per diem amount of $870.00 multiplied by the length of stay of 2 days yields a reimbursement amount of $1,740.00. This amount less the amount paid by the insurance carrier of $1,896.90 leaves an amount due of $0.00 for the medical admission.
12. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(c)(2)(B), §133.307(c)(2)(F)(ii), §133.307(c)(2)(F)(iii), §133.307(c)(2)(F)(iv) and §133.307(c)(2)(G). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §134.401
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

	Grayson Richardson	**3/21/2011**
Authorized Signature	Medical Fee Dispute Resolution Officer	Date
Authorized Signature	Medical Fee Dispute Resolution Manager	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.